Sweet Nothings? The BC Conversation on Health

Mots tendres ? Consultations sur la santé, en Colombie-Britannique

by ALAN DAVIDSON, PHD
Associate Professor, Health Studies
University of British Columbia Okanagan
Kelowna, BC

Abstract

On St. Valentine's Day 2006, the BC provincial government promised public discussions on healthcare. The ensuing Conversation on Health wrapped up last July. Meanwhile, the province has pursued more privately financed health construction projects (P3s) and tolerated expansion of the private healthcare subsector. The author reviews the differences between public consultation processes and the Conversation on Health, concluding that the principal aim of the BC government exercise was co-optation.

Résumé

Le jour de la Saint-Valentin, en 2006, le gouvernement de la Colombie-Britannique promettait des discussions publiques sur les services de santé. Les réunions intitulées « Conversation on Health » ont pris fin en juillet dernier. La province a mis en place plus de partenariats public-privé (PPP) pour des projets de construction liés à la santé

et a permis l'expansion du sous-secteur des services de santé privés. L'auteur compare les réunions « Conversation on Health » aux processus de consultation publique et conclut que la cooptation était le but principal de l'exercice du gouvernement de la Colombie-Britannique.

On St. Valentine's Day 2006, British Columbia's provincial government promised public discussions on healthcare. The short reference in the Throne Speech to a "province-wide conversation on health" followed two linked claims: (1) healthcare demand will inevitably rise because of the aging BC population and (2) the current level of public spending on healthcare services is not sustainable. The Throne Speech also announced an independent Foundation for Health Care Innovation and promised the premier would learn from systems that mix private with public healthcare financing by touring Europe (Government of BC 2006: 9). Thus, it was clear from the context not only what the government thought the problem was – excessive and rising public expenditure on healthcare – but also the solution: privately financed care supplementing or replacing publicly funded services. In short, an expanded private role in healthcare was to be the topic of conversation. In the end, however, the Conversation on Health provided fresh opportunity for those enamoured of universal, single-tier medicare to restate their case. Instead of *rapprochement*, a meeting of minds between government and its public, the Conversation illustrates the depth of the divide – a government from Mars and a public from Venus.

Given the tenor of the provincial government's Throne Speech, the September 28, 2006 formal launch of the Conversation on Health was met with cynicism. Reaction by the BC Health Coalition was typical: "We don't really trust this process because it appears that the premier has already decided we can't afford our public healthcare system and he intends to shape the debate around that view" (BC Health Coalition 2006). State-sponsored participation is rightly regarded with suspicion – a mechanism for manipulation and co-optation (Christiansen-Ruffman 1990). The risk of manipulation is particularly grave when the government's position has been unequivocally stated in advance of consultation. Even the opening question was a leading one: "Why are we so afraid to look at mixed health care delivery models?" (Government of BC 2006: 10).

Casting further doubt about the influence of public voices, the Speech from the Throne committed the government to act before hearing any of the conversation. The Throne Speech promised legislation enshrining the five principles of the federal *Canada Health Act* plus a new principle of sustainability. The target appears to be the federal government principle of accessibility, which is intended to preclude provincially authorized financial barriers to publicly funded health services. Sustainability, defined as "financial sustainability" of provincial healthcare financing, places limits on "free

access" whenever the pressure on the provincial treasury is judged by the provincial government to be too great. Unmentioned in the Throne Speech is the fact that British Columbia already has legislation enshrining the five principles of the *Canada Health Act*. The BC *Medicare Protection Act* was introduced by the New Democratic Party specifically to make it more difficult for subsequent BC governments to pursue private healthcare financing and delivery options. As the preamble puts it, "the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay" (*Medicare Protection Act* 1996). Thus, the Campbell government's commitment must mean either significantly amending or rescinding the *Medicare Protection Act*, presumably in order to permit private payment for hitherto guaranteed public health services. But nowhere does the government refer to this goal of user pay. Instead, the Throne Speech refers to "better access, greater choice, increased flexibility and new options" (Government of BC 2006: 11). Thus, it did seem disingenuous that the question: "How to strengthen the *Canada Health Act?*" was mandated for public discussion in the Conversation when the government had already unequivocally answered it.

Cynicism grew because both the BC government's purpose and methods were, and remain, questionable. Why, for example, did the government think more consultation was necessary? Extensive public consultations occurred in British Columbia during the New Directions healthcare reform in the mid-1990s (Davidson 1999) and continue up to the present, albeit mainly at the micro-level of health programs and services, through the Regional Health Authorities' Community Health Advisory Committees, patient focus groups and various ongoing regional and local public consultations (Vancouver Coastal 2006). Moreover, major public consultations on macro policy issues were conducted by the National Forum on Health in 1996 and the Commission on the Future of Health Care in Canada in 2002. The findings from those public consultations have been remarkably consistent. Canadians, including British Columbians, "want to keep the core principles of the Medicare model that accord with their strongly held values of universality, equal access, solidarity, and fairness" (Maxwell et.al 2002: vi). Among key themes from the recent Commission on the Future of Health Care rounds of consultation: (1) eliminating waste and improving management is only part of the solution; (2) primary care must incorporate more teamwork and improve coordination; (3) record keeping, communications and healthcare provider accountability must improve; (4) more funding is necessary; (5) additional funding should come from public sources, with increased taxes if necessary; (6) a parallel healthcare system ought not to be permitted; and (7) some private payment and market mechanisms may be appropriate as long as they are restricted to non-core/non-essential health services (Maxwell et al. 2002: vii). Subsequent national polling has yielded similar expressions of support for public funding of healthcare ("The Pollster Will See You Now" 2004).

Equally important is the question: How can consultation be meaningful and its results valid? "First, there must be a suspension of [government] action to create the political space for the deliberation to take place" (Rosenberg 2007: 340). This patently did not happen in British Columbia. Instead of a moratorium on healthcare change until the results of the Conversation were in, a premier fully satisfied that more private healthcare was workable and even desirable contributed to expansion of private healthcare. In light of the Throne Speech, the False Creek Surgical Centre, one of a number of private treatment clinics in the greater Vancouver area, decided to forge ahead with its plan to offer privately financed emergency and outpatient treatment services to walk-in clientele. Its owner wrote the government outlining his plans, and receiving no reply, assumed he was reading the signals correctly. When the clinic opened in late November 2006 to howls of protest, the government belatedly intervened. The private clinic reopened in April 2007 after recruiting doctors who were fully opted out of the provincial medicare plan and is currently operating unmolested by the Campbell government (Rolfsen 2007).

Second, once political space is created, participants must be representative of the relevant population, the process inclusive and means deployed to force meaningful deliberation over values and options (Rosenberg 2007). The National Forum and the Commission on the Future of Health Care came close to meeting those requirements. The Citizens' Dialogue on the Future of Health Care, for example, employed random sampling, scenario construction supported by well-evidenced reports and, perhaps most importantly, design features that forced citizen participants to identify and make trade-offs as opposed to merely tabling observations and suggestions. The Conversation fell far short. Rather than a cross-section of citizens, participants were essentially self-selected. Once discussions were convened, no effort was made to confront differences in values or create a coherent vision of the healthcare system. Participants were free to render whatever comments and observations they had, essentially context-free, without consideration of trade-offs or opportunity costs.

Despite the lack of methodological rigour, the government's approach to consultation at least seemed fair from a procedural standpoint. The Conversation was designed to be open, with questions and issues posed by government but with allowance for citizens to suggest other matters for discussion (Ministry of Health 2007a). Features of the Conversation included a plan for 16 regional forums of 100 lay participants. (Professional healthcare providers were excluded, but paraprofessional and alternative healthcare providers were welcome.) Later, in reaction to criticism, the government added focus groups of professional healthcare providers.

However, public response, perhaps because of the background conditions, was muted. Out of British Columbia's over-19 population (3,339,470), a total of 4,586 (0.1372%) applied to attend the 16 forums (Statistics BC; personal communication BC Ministry of Health, April 27, 2007). Although the target size of each forum was

100 participants, only between 61 and 88 were actually recruited to the 11 forums held before May 1, 2007, with a mean attendance figure of 75 (Ministry of Health 2007b).

Participants were mailed a Regional Public Forum Participant Registration Package consisting of a letter from the minister of health and 11 "conversation starters." The packages made clear the difference between what was envisaged in the Conversation and a citizen deliberative process. Citizen deliberation relies on balanced expert opinion with regard to technical issues and strategies, looking to citizens primarily for synthesis and consensus on normative dimensions (Abelson et al. 2003, 2007; Dryzek 2000). The conversation starters, in contrast, were deliberately one-sided and provocative. For example, starters feature highlighted text boxes with such content as, "Did you know in Sweden and France, patient cost-sharing and co-payments are required for many services, such as doctor's visits, hospital care, medical devices and pharmaceuticals?" Those claims appear without context, explanation or reference. One starter, "About Seniors and Aging," resorts to apocalyptic demography. Projections of growth in numbers of seniors are coupled with the statement "studies show that people in their 90s use approximately $22,000 in health services each year – 10 times what people use on average in their 50s" (Ministry of Health 2007b).

Strangely, though, forum facilitators did not use the starters, indeed barely referred to them. The format of the regional forums, to the government's credit, left participants free to suggest areas of discussion and to choose their own focus groups and topics. Government reports on regional forum discussions indicate participants set their own agenda and largely ignored the government's resource material. Strong support for existing public programs is the common thread, along with recommendations for their expansion into more effective home care and drug programs (Ministry of Health 2007c). While many excellent ideas have been expressed for healthcare improvements, there has been little evidence of appetite for more healthcare privatization or private financing. This is scarcely surprising, as one would expect the supporters of medicare to mobilize against a government they regard as misguided, whereas those supporting the government no doubt believe it will travel its established course (Contrandriopoulos 2004).

At first glance, the Conversation is an example of British Columbia's commitment to citizen deliberation. It is apparent that the BC government has been influenced by trends in California, the United Kingdom and elsewhere to use deliberative bodies to resolve policy issues. In fact, the province was briefly a leader in this regard when the Campbell government chose to use a citizen panel, the BC Citizens' Assembly, to research and identify for government appropriate changes to the BC provincial electoral system. The government followed through by taking the Assembly's recommendation to the general public in a 2005 referendum – a high point in BC democracy. Unfortunately, the Conversation, in contrast, marks something of a low point.

The complexity and expense, and the language of deliberation and consensus

building, imply the government must have been reaching for something beyond mere information seeking – not just "consultation" but some kind of "citizen participation" (Culyer 2005). However, while superficially deliberative, the Conversation's eclectic mix of face-to-face discussions, electronically mediated communications and "conversation starters" were not designed to yield specific recommendations or even focus on any specific questions. The website and the minister's letter to forum participants talked only vaguely about information gathering. Characterizing the activity as merely information gathering is accurate, because the Conversation is not any known form of citizen participation in policy formation – it does not fit the typology of citizens' panel, deliberative polling, consensus conferencing, citizen's jury or planning cell (Abelson et al. 2003; Pratchett 1999). That incongruity makes sense if and only if the Conversation is not about informing healthcare policy making.

If the Conversation is not about policy making, what could it conceivably be about, apart from a random collection of inputs? Government's goals could be one or all of the following three possibilities: educative, socially integrative and co-optive. Educative goals could include helping citizens to see how complex and difficult healthcare policy decision-making can be or simply getting healthcare-related information in circulation. It is easy to see how either could diffuse resistance to unpopular policy. Socially integrative goals might include fostering democratic norms of debate and tolerance or, more fundamentally, transforming participants through their interaction with fellow citizens. Those are undoubtedly valuable things, but how they link to government's healthcare agenda is unclear, except perhaps to diffuse dissent, which leads directly to co-optation. Essentially, co-optation boils down to using the Conversation as a cloaking and legitimating device for predetermined outcomes.

But all good romances involve mystery and surprises. Starting with this surprise: the government made good on reporting honestly the feedback it received through the Conversation. That feedback is the familiar National Forum and Romanow Commission refrain. "Most participants in the Conversation on Health argue for the maintenance of a fully publicly delivered and funded system" (Ministry of Health 2007d: 4). Favoured solutions are: publicly funded primary care centres, faster implementation of best practices and implementation of the Romanow Report recommendations (Ministry of Health 2007e: 7). The mysteries are, "What did government expect?" and "What will they make of the feedback, given their position as expressed in the Throne Speech?"

Correspondence may be directed to: Alan Davidson, Associate Professor, Health Studies, University of British Columbia Okanagan, 3333 University Way, Kelowna, BC V1V 1V7; tel: 250-807-9969; e-mail: alan.davidson@ubc.ca.

REFERENCES

Abelson, J., P.-G. Forest, J. Eyles, A. Casebeer, E. Martin and G. Mackean. 2007. "Examining the Role of Context in the Implementation of a Deliberative Public Participation Experiment: Results from a Canadian Comparative Study." *Social Science and Medicine* doi:10.1016/j.socscimed, 2007.01.013.

Abelson, J., P.-G. Forest, J. Eyles, P. Smith, E. Martin and F.-P. Gauvion. 2003. "Deliberations about Deliberative Methods: Issues in the Design and Evaluation of Public Participation Processes." *Social Science and Medicine* 57: 239–51.

BC Health Coalition. 2006 (September 28). "BC Health Coalition Suspicious of Liberal Government 'Conversation.'" BC Health Coalition News Release, September 28, 2006.

Christiansen-Ruffman, L. 1990. "On the Contradictions of State-Sponsored Participation." In R. Ng, G. Walker and J. Muller, eds., *Community Organization and the Canadian State* (pp. 85–107). Toronto: Garamond Press.

Commission on the Future of Health Care in Canada. 2002. "Backgrounder: Report on a Citizens' Dialogue on the Future of Health Care in Canada." Retrieved May 14, 2008. <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/FINALcprnbackgrounderE%20logos.pdf>.

Contrandriopoulos, D. 2004. "A Sociological Perspective on Public Participation in Health Care." *Social Science and Medicine* 58: 321–30.

Culyer, T. 2005 (November 17–18). "Deliberative Processes and Evidence-Informed Decision-making in Health Care." Institute for Research into Public Policy. *Health Services Restructuring: New Evidence and New Directions*. Kingston, Ontario. Retrieved May 14, 2008. <http://www.irpp.org/events/archive/nov05JDI/index.htm>.

Davidson, A. 1999 (December). "British Columbia's Health Reform: New Directions and Accountability." *Canadian Journal of Public Health* 90 (Suppl. 1): 35–38.

Dryzek, J. 2000. *Deliberative Democracy and Beyond: Liberals, Critics, Contestations*. New York: Oxford University Press.

Government of BC. 2006 (February 14). Legislative Assembly of British Columbia Speech from the Throne, 2006 Legislative Session: 2nd Session, 38th Parliament. Retrieved May 14, 2008. <http://www.leg.bc.ca/38th2nd/4-8-38-2.htm>.

Maxwell, J., K. Jackson, B. Legowski, S. Rosell, D. Yankelovich, P-G Forest and L. Lozowchuk. (2002) *Report on Citizens' Dialogue on the Future of Health Care in Canada*. Ottawa, Ontario. Retrieved May 23, 2008. < http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/Dialogue_E.pdf>.

Medicare Protection Act. 1996. *Medicare Protection Act* RSBC 1996, c. 286.

Ministry of Health. 2007a. *Conversation on Health*. Retrieved May 14, 2008. <http://www.bcconversationonhealth.ca>.

Ministry of Health. 2007b. Conversation on Health Regional Public Forum Participant Registration Package. Victoria, BC: Author.

Ministry of Health. 2007c. Conversation on Health Regional Public Forums. Retrieved May 14, 2008. <http://www.bcconversationonhealth.ca/EN/regional_public_forums/>.

Ministry of Health. 2007d. Conversation on Health What British Columbians are Saying About Health, volume 34. Retrieved May 23, 2008. <http://www.bcconversationonhealth.ca/media/What%20British%20Columbians%20Are%20Saying%20Report_May21%20to%20May27_VOL%2034_final.pdf>

"The Pollster Will See You Now: Canadians Speak Out on Health Care." 2004 (December 20). *Maclean's* 117(51): 31.

Pratchett, L. 1999 (October). "New Fashions in Public Participation: Towards Greater Democracy?" *Parliamentary Affairs* 52(4): 616–34.

Rolfsen, C. 2007 (April 9). "Private Clinic Reopens under New Operating Scheme." *Vancouver Sun*. Retrieved May 14, 2008. <http://www.canada.com/components/print.aspx?id=8253cfe3-718d-4e1b-9f27-e3f740b9ac90&k=8837>.

Rosenberg, S. 2007. "Rethinking Democratic Deliberation: The Limits and Potential of Citizen Participation." *Polity* 39(3): 335–60.

Statistics BC. 2007. Population Estimates, Standard Age Groups, July 1, 2000. Retrieved May 14, 2008. <http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/>.

Vancouver Coastal Health. 2007. *The role of the Health Authority in Population Health: A perspective from Vancouver Coastal Health's Community Health Advisory Committees*, Vancouver, British Columbia. Retrieved May 23, 2008. <http://www.bcconversationonhealth.ca/media/Conversation_on_Health_and_Population_Health.pdf>.

Call to Authors

DISCUSSION AND DEBATE

The Discussion and Debate section of *Healthcare Policy* offers a forum for essays and commentaries that address: (1) important health policy or health system management issues; or (2) critical issues in health services and policy research. Submissions should be a maximum of 2,000 words exclusive of (no more than 20) references. The main points of the paper should be highlighted in an abstract (summary) of 100 words or less.

Appel aux auteurs

DISCUSSION ET DÉBAT

La section « Discussion et débat » de *Politiques de Santé* offre un forum pour la publication de comptes rendus et de commentaires portant sur les sujets suivants : (1) d'importantes questions liées aux politiques de santé ou à la gestion du système de soins de santé; ou (2) des questions cruciales concernant les services de santé et la recherche sur les politiques. Les articles devraient être d'au plus 2 000 mots, sans compter les références (pas plus de 20). Les points saillants de l'article devraient être mis en évidence dans un résumé (sommaire) de 100 mots ou moins.

For more information contact Ania Bogacka, Managing Editor, at abogacka@longwoods.com.

Pour de plus amples renseignements, veuillez communiquer avec Ania Bogacka, Directrice de rédaction, à abogacka@longwoods.com.